November 19, 2009

To: **PCMH Workgroup Members**

From: **Ben Steffen**

Subject: **Identification of Quality Measures**

At the conclusion from November 6th meeting, the participants agreed that identification of composite measures to assess the quality in a PCMH was not desirable because the existing instruments would be expensive to implement. The participants felt that the selection of discrete quality measures across the PCMH domains was the better approach.

Dr. White, Ms. Epke, Karen Rezabek, and I had a conference call on Tuesday evening to further discuss a revised approach. We came up with some broad criteria to guide measure selection that are listed below.

Criteria for Quality Measure Selection
1. National Quality Forum endorsement
2. Established and supported in provider community
3. Potential for consistency in measurement – can be gathered pre-test, test, post-test
4. Parsimony – reporting is not excessively cumbersome and can be sustained over time
5. Availability of strong external bench marks

Using those criteria, I selected a super set of potential measures as a starting point for the discussions. The list is show in Attachment 1. The key word with regard to the list is that this is a "starting point" for the discussion. I expect others will have recommendations.
I am also am including the Joint Principles and the broad evaluation questions that a suggested PCMH pilot must answer before the model could be launched broadly.

I'll look forward to our discussion this afternoon.

Principles of the PCMH from the Joint Principles

1. ***Personal physician*** - each patient has an ongoing relationship with a personal physician - first contact, continuous and comprehensive care.
2. ***Physician directed medical practice*** – the personal physician leads a team of individuals
3. ***Whole person orientation*** – the physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes acute care; chronic care; preventive services; and end of life care.
4. ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public, and private community-based services)
5. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
6. ***Quality and safety***
    a. Evidence-based medicine and clinical decision-support tools guide decision-making
    b. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
    c. Patients actively participate in decision-making, and feedback is sought to ensure that patients' expectations are being met.
    d. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
    e. Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
    f. Patients and families participate in quality improvement activities at the practice level.
7. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
8. Payment reform

Questions to answered be through a PCMH -Pilot

1. Will the PCMH improve clinical care process?
2. Will the PCMH improve patient access to appropriate and coordinated care?
3. Will PCMH enhance patients' experiences of care?
4. Will clinician and staff satisfaction with practice work style improve?
5. Will the PCMH lower the total costs of care?